ARCHDIOCESE OF LOUISVILLE
BENEFIT ENROLLMENT FORM - 2015 PLAN YEAR

PARISH, SCHOOL, AGENCY:_____ **Subgroup #:** _____

EMPLOYEE INFORMATION (please print clearly)

Name:_____ **SSN**_____
Last First Middle

Home Phone:_____ **Work Phone:**_____

Home Address:_____
Street City State Zip

Date of Birth: _____ **Sex:**_____ **Marital Status:**_____

Original Hire Date: _____ **Job Title:**_____

Local Hire Date: _____

Hours Worked (per week):_____ **Weeks Worked (per year):**_____ **Annual Salary: $**_____

Employees must work 30+ hours per week and 1,000 hours per year to be eligible for benefits.

BENEFITS PROVIDED BY THE ARCHDIOCESE OF LOUISVILLE

☐ **TERM LIFE INSURANCE**

Beneficiary's Name:_____ **Relationship:**_____
Last First Middle

☐ **LONG TERM DISABILITY COVERAGE**

BENEFITS PAID FROM EMPLOYEE PRE-TAX INCOME

MEDICAL COVERAGE (Check one)

Coverage First

☐ **Individual** **$487.64** ☐ **Employee +1** **$975.28** ☐ **Family** **$1,462.88**

☐ **If I have elected to cover my spouse under my medical coverage, I hereby advise that my spouse is not eligible for coverage under his/her employer. By signing this form below, I certify this information to be true and correct to the best of my knowledge and understand that any misstatement constitutes fraud.**

☐ **I do not elect medical coverage.**

DENTAL COVERAGE (Check one)

Preventive Plus		Humana PPO		Traditional Preferred	
☐ EE	$14.34	☐ EE	$25.96	☐ EE	$34.80
☐ EE+SP	$31.26	☐ EE+SP	$45.88	☐ EE+SP	$69.12
☐ EE+CH	$35.06	☐ EE+CH	$50.92	☐ EE+CH	$70.48
☐ Family	$54.56	☐ Family	$87.22	☐ Family	$114.34

☐ **I do not elect dental coverage.**

FLEXIBLE SPENDING ACCOUNTS - Indicate amount to be contributed in whole dollars.
Any monies remaining in spending accounts at plan year end will be forfeited in accordance with IRS regulations.

☐ **Health Care Account $**_____ **per month (minimum $75 per month; maximum $2,500 per year)**

☐ **Dependent Care Acct $**_____ **per month (minimum $75 per month; maximum-see plan booklet)**

☐ **I do not elect to participate in the Flexible Spending Accounts.**

BENEFITS PAID FROM EMPLOYEE TAXABLE INCOME

☐ **SHORT-TERM DISABILITY (see plan booklet for rates)**

☐ **I do not elect Short-term Disability**

I have received the 2015 Summary Plan Description and understand that I cannot change my benefit elections, except for specific reasons permitted by the IRS, until the next open enrollment.

EMPLOYEE SIGNATURE:_____ **DATE:**_____

BOOKKEEPER/ADMINISTRATOR:_____ **DATE:**_____

NOTE: Original For Parish Files; Pink To Employee; Yellow To Chancery.